Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005015	A. BUILDING _____ B. WING _____	07/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ANTHONY HEALTH - MICHIGAN CIT	301 W HOMER ST MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of one hospital licensure complaint. Complaint Number: IN00104707 Unsubstantiated: Lack of sufficient Evidence Date: 7/24/12 and 7/25/12 Facility Number: 005015 Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor Franciscan St. Anthony Health--Michigan City is in compliance with 410 IAC 15-1.5-2, Infection Control; 410 IAC 15-1.5-7, Pharmaceutical Services; and 410 IAC 15-1.6.8, Other Services (Surgical Services), Indiana Hospital Licensure Rules. QA: claughlin 08/01/12	S 000		

Indiana State Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE